Uniform Medical Plan
Your health. Your plan. Your choice.

Claim Form

Instructions

1. Submit one claim per patient.
2. Attach itemized bills, including patient s name, date of service, diagnosis, and charge.
3. Retirees covered by Medicare who do not have an itemized bill need only attach a copy of the Explanation of Medicare Benefits (EOMB) form. Be sure to complete Section 3 of this form to avoid claims delay.
4. If services were rendered by a Uniform Medical Plan preferred provider and if the Uniform Medical Plan is the primary plan (meaning it pays before any other plan), you need not file a claim.
5. Mail your completed claim to: **Uniform Medical Plan, P.O. Box 34850, Seattle, WA 98124-1850.**
6. Do not use this form for prescription drug or dental claims.

Questions? Actives: 1-800-762-6004; (425) 670-3000 Seattle
Retirees: 1-800-352-3968; (425) 670-3150 Seattle

Section 1 – Subscriber Information

A. Subscriber Social Security No. ☐☐☐-☐☐-☐☐☐☐

B. Subscriber Name _____ Birth Date ____/____/____
Last Name First Name M.I. Mo. Day Yr.

C. Subscriber Home Address _____
Street Address

_____
City State ZIP Code + 4 Work Phone Number Home Phone Number

D. Has your address changed since your last claim? ❑ Yes ❑ No

Section 2 – Patient Information *Do not complete if patient is subscriber. Go to Section 3.*

A. Patient Name _____ Birth Date ____/____/____
Last Name First Name M.I. Mo. Day Yr.

B. Relationship to subscriber
- ❑ Spouse
- ❑ Dependent stepchild
- ❑ Dependent child under age 20
- ❑ Dependent disabled child age 20 or above
- ❑ Dependent full-time student (age 20 through 23)
- ❑ Other Specify: _____

Proof of student status must be provided quarterly.

C. Is patient employed? ❑ Yes, full-time ❑ Yes, part-time ❑ No

If yes: _____
Name of Employer

_____
City State ZIP Code + 4 Employer s Phone Number

Section 3 – Provider Information

Complete this section if the provider information is not included on the bill.

_____ Provider Name	_____ Provider Name
_____ Specialty	_____ Specialty
_____ Address	_____ Address
_____ City State ZIP Code + 4	_____ City State ZIP Code + 4
☐☐☐☐☐☐☐☐☐ Tax ID Number (if known)	☐☐☐☐☐☐☐☐☐ Tax ID Number (if known)

PLEASE COMPLETE REVERSE SIDE

Section 4 – Accident or Work-Related Injury Information

A. Is this claim the result of a work-related illness or injury? ❑ Yes ❑ No

B. Is this claim due to any accident or injury? ❑ Yes ❑ No
If you answered no to both questions, go to Section 5.

C. Was illness or injury due to ❑ Auto Accident ❑ Other Specify: _____

D. Date accident occurred _____/_____/_____
Mo. Day Yr.

E. Was a police report filed? ❑ Yes ❑ No ***If yes, you must submit a copy of the police report with this claim.***

F. If auto accident, was patient wearing a seatbelt? ❑ Yes ❑ No
If motorcycle or bicycle accident, was patient wearing a helmet? ❑ Yes ❑ No

G. Explain where and how the illness or injury occurred _____

_____

H. Auto or home owner s insurance company _____
Name of Insurer

_____
Street Address City State ZIP Code + 4 Phone Number

I. Insurance company of any third party involved with this loss _____
Name of Insurer

_____
Street Address City State ZIP Code + 4 Phone Number

J. Do you intend to seek repayment of medical expenses and/or work time lost for you or your dependent?
❑ Yes ❑ No Uncertain at this time

K. Will you file for any disability benefits? ❑ Yes ❑ No Uncertain at this time

L. Will you contact an attorney in this matter? ❑ Yes ❑ No Uncertain at this time

M. If yes: _____
Name of Attorney

_____
Street Address City State ZIP Code + 4 Phone Number

Section 5 – Other Coverage

A. Are patient s medical expenses covered by another employer s group health insurance, welfare, or government plan? ❑ Yes ❑ No
If yes, and the other plan is primary, a copy of the Explanation of Benefits from the other plan must be attached.

If yes, name of subscriber carrying other group coverage _____
Name

_____
Street Address City State ZIP Code + 4

_____
Name of Plan Group Number

B. Is patient covered by Medicare? ❑ Yes ❑ No
If no, go to Section 6. If yes, is a copy of the Explanation of Medicare Benefits enclosed?

C. What type of Medicare coverage does patient have? ❑ Part A (Hospital) ❑ Part B (Physician)

D. Is Medicare coverage due to kidney disease? ❑ Yes ❑ No

E. Is Medicare coverage due to disability? ❑ Yes ❑ No

Section 6 – Authorization to Pay

Have you paid for these charges? ❑ Yes ❑ No ***Preferred providers are paid directly.***

I certify this information is correct and authorize its release as required for administration of this claim.

_____ _____
Signature of Subscriber/Patient (Parent, if minor) Date